

Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

Chapter 10 Maryland Trauma Physician Services Fund

Authority: Health-General Article, §§19-103(c), 19-130, and 19-207, Annotated Code of Maryland

.07 Payments for Uncompensated Care Patients.

A. A trauma physician or trauma health care practitioner:

(1) Is eligible for payment from the Fund for trauma services provided to uncompensated trauma care patients with an admission date on the Maryland Trauma Registry beginning on or after July 1, 2024; and

(2) May seek reimbursement in accordance with this regulation.

B. The cost of uncompensated care incurred by a trauma physician or trauma health care practitioner in providing trauma care to a trauma patient as defined in this chapter shall be reimbursed at a rate of up to 100 percent of the current Medicare facility-based payment for a service in the Baltimore carrier locality area, less any amount for trauma physician or trauma health care practitioner services paid by the patient or other third-party payors including, but not limited to, auto insurance, criminal injuries compensation fund, attorneys, or collection agencies, as reported to the Fund on the uncompensated services claim.

C. An organization billing on behalf of trauma physicians or trauma health care practitioners eligible for uncompensated care payments shall:

(1) Designate a trauma service by appropriate coding of the U1 Modifier (or any successor modifier that includes that same data) on the electronic ANSI 837 transaction or paper CMS 1500 claim in accordance with claims submission requirements; and

(2) Include the patient's trauma registry number on the electronic claim or on the CMS 1500.

D. Diagnosis Code.

(1) Coding shall be consistent with CMS ICD-10 CM guidelines, or any successor guidelines.

(2) A diagnosis code shall fall between ICD-10 CM S00 - T88 range (or their successor codes indicating trauma-related diagnoses).

(3) External cause codes.

(a) A diagnosis code may also be accompanied by secondary code or codes indicating external cause of injury, denoted by ICD-10 CM V, W, X, Y, or Z codes (or their successor codes indicating external cause of injury).

(b) External cause codes may not be sequenced as the first-listed or principal diagnosis.

E. To be eligible for uncompensated care differential payment described in §B of this regulation, the place of service code shall have one of the following values:

(1) Appropriate code for "acute care inpatient hospital";

(2) Appropriate code for "outpatient hospital";

(3) Appropriate code for "emergency room"; or

(4) Appropriate code for "rehabilitation hospital".

F. The uncompensated services claim shall:

(1) Document uncompensated care services not previously claimed under the Fund;

(2) Exclude services for trauma patients who have applied for assistance through Medicaid, but who have not received a final eligibility determination;

(3) Exclude noncovered services that the trauma physician or trauma health care practitioner provided to trauma patients covered by health insurance;

(4) Exclude services for trauma patients covered by health insurance for which the trauma physician or trauma health care practitioner failed to comply with the insurer's coverage rules or claim filing requirements; and

(5) Have a date of service on the claim not older than 5 years.

G. Uncompensated care services are eligible for reimbursement from the Fund only after a faculty practice plan, a physician practice, a trauma center on behalf of a trauma physician or trauma health care practitioner, an individual trauma physician or an individual trauma health care practitioner has completed its collection efforts using the respective entity's documented policies and procedures.

H. Order of Preference.

(1) To minimize administrative costs in administering the Fund, the order of preference for the entity submitting an uncompensated services claim is as follows:

- (a) Faculty practice plan;
- (b) Physician practice;
- (c) Trauma physician;
- (d) Individual trauma health care practitioner.

(2) The preference specified in §H(1) of this regulation refers to the submitting entity and not the preference for distributing payments.

I. A trauma patient treated at an out-of-State pediatric trauma center that has entered into an agreement with MIEMSS shall be a Maryland resident in order for the trauma physician or trauma health care practitioner to file an uncompensated services application for an uncompensated care shortfall payment. The determination of whether a trauma patient is a Maryland resident shall be based on the trauma patient's demographic information as listed on the Maryland Trauma Registry.

J. The uncompensated services claim shall contain the following information:

- (1) The name and federal tax identification number of the trauma physician or trauma health care practitioner rendering the care;
- (2) The date of the service;
- (3) Appropriate codes describing the service;
- (4) Any amount recovered for the service rendered;
- (5) The name of the trauma patient;

(6) The trauma patient's Maryland Trauma Registry number;

(7) Date of the original trauma injury;

(8) The diagnosis codes that were treated;

(9) The procedure and service codes performed; and

(10) Other information requested in the claim.

K. The Commission, in consultation with the Health Services Cost Review Commission, may establish a payment rate for uncompensated care incurred by a trauma physician or trauma health care practitioner in providing trauma care to trauma patients that is above the 100 percent of Medicare payment for the service if:

(1) The Commission determines that increasing the payment rate above 100 percent of the Medicare payment for the service will address an unmet need in the State trauma system;

(2) The source of revenue increases and the projected current uses of the Fund decline;

(3) The Commission considers data analyses of trauma care rendered at Maryland trauma centers for CPT codes reimbursed as uncompensated care as reported to the Maryland Medical Care Data Base; and

(4) The Commission reports on its intention to increase the payment rate to the Senate Finance Committee and the House Health and Government Operations Committee, at least 60 days before any adjustment to the rate.